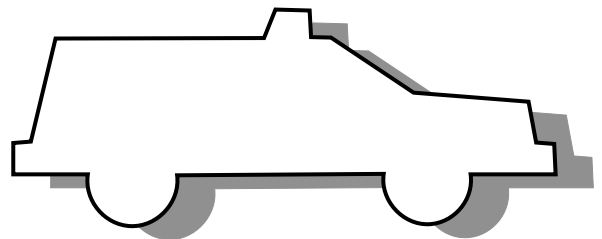
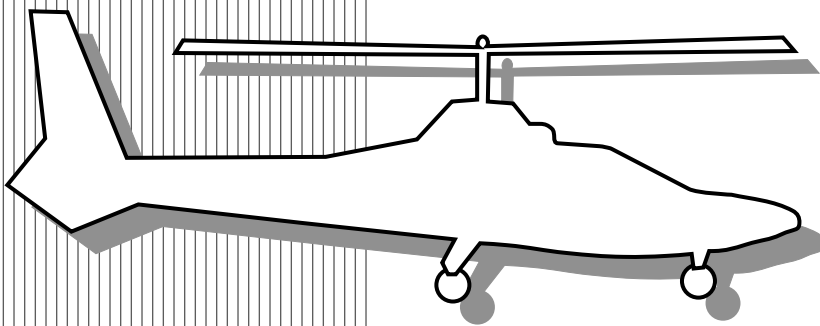


Maryland Ambulance Information System

USER'S MANUAL



July 2003 Revision

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SECTION 1: MARYLAND AMBULANCE INFORMATION SYSTEM CHANGES EFFECTIVE JULY 1, 2003

Effective July 1, 2003, the Maryland Ambulance Information System (MAIS) form will incorporate several modifications. Each modification is listed below.

1. REVISION DATE The Revision Date at the top of the form has been changed to (Rev. 07/03).
2. DATE The responses in the Year portion of the Date field have been changed to '03', '04', '05', '06', '07'.
3. MEDICATIONS (Deleted) The following Medications have been deleted:
 Droperidol
 Heparin
4. MEDICATIONS (Additions) The following Medications have been added:
 Haloperidol
 Ipratropium
 MARK I Kit (Atropine Auto and 2PAM Cl Auto)
 Saline Nebulizer
5. OTHER CARE There are now two responses for Restraints; one response for Chemical Restraint, one for Physical Restraint. The Chemical response bubble contains the letter 'C'. The Physical response bubble contains the letter 'P'.
6. REASON HOSPITAL
 CHOSEN A 'Stroke Care' response has been added to the Reason Hospital Chosen section to identify patients who were transported to a particular facility based on Stroke protocol.
7. COPYRIGHT YEAR The Copyright year (bottom left corner of the form) has been changed to 2003.

(Rev. 07/03)

DATE		
Month	Day	YR
<input type="radio"/> Jan		
<input type="radio"/> Feb		
<input type="radio"/> Mar	01 01	
<input type="radio"/> Apr	01 01	03
<input type="radio"/> May	02 02	
<input type="radio"/> Jun	03 03	04
<input type="radio"/> Jul	04	
<input type="radio"/> Aug	05	05
<input type="radio"/> Sep	06	
<input type="radio"/> Oct	07	06
<input type="radio"/> Nov	08	
<input type="radio"/> Dec	09	07

**G
E
N
D
E
R**

Receiving

SECTION 2: JURISDICTION, PATIENT, AND PROVIDER IDENTIFICATION

Use Section 2 of the MAIS form to record jurisdictional, patient, and provider identification information. Some areas of Section 1 are local options. You may not be required to complete all data for Section 2. Check with your company and jurisdictional EMS officers to determine which areas you are required to complete.

MARYLAND AMBULANCE INFORMATION SYSTEM															(Rev.) 07/03
Station Run Number	Jurisd Incident Number	Supl	Box Number	District	Receiving Facility:										
						Other Units on Scene:									
Response Location:			Zip Code			Inc Type	Occup	Action	Disp						
Patient Name:			Provider 1 ID Number			Provider 1 Name									
Parent/ Guardian:			Provider 2 ID Number			Provider 2 Name									
Patient Address:			Provider 3 ID Number			Provider 3 Name									
Home Phone:															

Station Run Number Record your Company's identification number for the current call - **local option.**

Jurisd Incident Number Record your jurisdiction's incident number for the current call - **local option**.

Supl Record the number of **supplements** related to the current incident. For example, the MAIS forms for two persons injured in a motorcycle crash would each have one supplement. The supplement shows one additional record was produced for this call. This is a **local option** field.

Box Number	The location identification number for the current call - local option .
-------------------	---

District Record your jurisdictional response district number - **local option**.

Receiving Facility Record the name of the receiving facility to which you transported this patient.

Other Units on Scene Identify other emergency units responding to this call.

Response Location	Record the location where your unit encountered the patient. Be as specific as possible. For example, record the exact street address to which you responded for a medical call, names of intersecting streets for vehicular accidents, or another geographic location description, such as Memorial Park, for a child with seizure.
--------------------------	--

Zip Code Record the zip code for the location to which you responded

Inc Type Record the **type of incident** encountered on this call - **local option**.
If you are required to record incident types, you can obtain the necessary documentation from your company or jurisdiction.

Occup	Record the occupancy type for the location you responded to for this call - local option . If your jurisdiction requires occupancy types, documentation for occupancy types should be available from your jurisdiction.
Action	Record the actions data required by your jurisdiction - local option . Documentation for the actions field is available from your jurisdiction if you are required to complete this field.
Disp	Record the disposition of this call - local option . Documentation for disposition of calls should be available from your jurisdiction if you are required to complete the disposition field.
Patient Name	Print the patient's last name, first name, middle initial.
Parent/Guardian	In the case of a minor child, print the last name, first name, of the child's parent or legal guardian.
Patient Address	Print the patient's residential address . Note that the residence address may differ from the response location.
Home Phone	Print the patient's home phone number. Include the area code.
Provider 1 ID Number Provider 2 ID Number Provider 3 ID Number	Record the unique numeric identifiers for the providers on this call. Provider 1 should be the highest EMS certified member of the crew. Record provider ID numbers using block style print (0,1,2,3,4,5,6,7,8,9).
Provider 1 Name Provider 2 Name Provider 3 Name	Print the provider's names in the order that corresponds to the Provider ID #'s. Not all jurisdictions require provider names on the MAIS report. You should check with your jurisdiction for specific instructions regarding provider names.

SECTION 3:

CALL DATE/MAIS NUMBER

CALL DATE

Mark the month, day, and year responses for your call date in the fields provided. The **month** and **year** responses are pre-labeled. The **Day** portion of the date field requires that you mark **two** responses. Dates between the first and ninth of the month should be recorded as '01', '05', '09', etc. Space has been provided to print the day and year values.

DATE		
Month	Day	YR
<input type="radio"/> Jan		
<input type="radio"/> Feb		
<input type="radio"/> Mar	0 0	
<input type="radio"/> Apr	1 1	03
<input type="radio"/> May	2 2	
<input type="radio"/> Jun	3 3	04
<input type="radio"/> Jul	4	
<input type="radio"/> Aug	5 05	
<input type="radio"/> Sep	6	
<input type="radio"/> Oct	7 06	
<input type="radio"/> Nov	8	
<input type="radio"/> Dec	9 07	

9801002

MAIS NUMBER

The **MAIS Number** section consists of two parts; the seven-digit unique number pre-printed on each form, and a computer-coded representation of that number. You should take particular care not to make stray marks in this area. Even slight marks in this area can change the computer-coded value of the pre-printed number.

SECTION 4: DOCUMENTATION OF RESPONSE TIMES

You should document each **response time** for your call in Section 4. Response time data allow standardized evaluation of time intervals within jurisdictions as well as statewide. Please darken the responses for all time intervals that apply to your current call.

DOCUMENTATION OF TIMES																							
911 Call			Amb Call			Dpt Sta			Arv Loc			Dpt Loc			Arv Hosp			Rtn Serv					
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1			
2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2			
3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3			
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4			
5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5			
6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6			
7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7			
8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8			
9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9			

911 CALL

Time the **911 dispatcher received the call** for EMS intervention.

AMB CALL

The time **your station was notified** of the call.

DPT STA

The time your **unit departed the station**.

ARV LOC

The time your **unit arrived at the location** of the incident.

DPT LOC

The time your **unit departed the location**. The depart location time should be completed regardless of whether or not your unit transports a patient.

ARV HOS

The time your **unit arrived at the receiving facility**. The arrive hospital time should be left blank if the call results in no patient transport.

RTN SERV

The time your **unit is available** for the next request for EMS intervention. The return service time should be recorded each time you respond to a call.

Space is provided below each time interval heading to print the time if you wish to do so.

SECTION 5: RESPONSE IDENTIFICATION, NO CARE RENDERED, TRIAGE PRIORITY

Use Section 5 to identify your unit's base jurisdiction number, identification number, staffing level, dispatch level (ALS/BLS), first due, no care rendered, and triage priority data.

CTY (County, City code)

RESPONSE IDENTIFICATION									
Cty		Unit							
0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9

Mark the responses that correspond to your unit's base county or city (**CTY**). This code should always reflect your unit's base jurisdiction number even though you may respond to another jurisdiction. Space is provided below the CTY heading to print your jurisdictional code. Jurisdictional codes can be found in Appendix B.

UNIT

Record your unit's identification number by darkening the corresponding responses in the **UNIT** section.

HIGHEST STAFF

High Staff
<input type="radio"/> IVT
<input type="radio"/> EMT-B
<input type="radio"/> CRT
<input type="radio"/> CRT-I
<input type="radio"/> EMT-P
<input type="radio"/> Other

Indicate the highest certification level among the providers on your unit. **Mark only one certification level.** The "Other" response should be marked if the highest certification level is not listed.

DISPATCH

DISPATCH
<input type="radio"/> ALS
<input type="radio"/> BLS

Mark the **ALS** or **BLS** response based on the **life support level** assigned to this call at dispatch. **Mark only one dispatch level.**

FIRST DUE

1st Due
<input type="radio"/> Yes
<input type="radio"/> No

Mark **Yes** if your unit was considered the first due unit for this call. If your unit was not the first due, mark the **No** response. **Mark only one first due response.**

NO CARE RENDERED
<input type="radio"/> PDOA <input type="radio"/> Cancel <input type="radio"/> False <input type="radio"/> No Pt <input type="radio"/> Refuse <input type="radio"/> Unit 2

NO CARE RENDERED

If you were dispatched to a call that resulted in no patient care by your unit, you should indicate the reason no care was required. Mark only one response.

- PDOA** Patient was **Presumed Dead on** the **arrival** of your unit at the scene.
- Cancel** Your response was cancelled while your unit was en route or upon the arrival of your unit at the scene.
- False** The call was determined to be false; EMS was not required.
- No Pt** The potential need for patient care existed but was not required, **standby** status.
- Refuse** Patient refused all care and transportation.
- Unit 2** Your unit was not required to provide care because other unit(s) at the scene were managing the patient(s).

PRIORITY
<input type="radio"/> One <input type="radio"/> Two <input type="radio"/> Three <input type="radio"/> Four <input type="radio"/> N/A

PRIORITY

Record the triage priority for your patient based on Maryland EMS guidelines.

- One** Critically ill or injured. Requires immediate attention. A delay in treatment may be harmful to patient.
- Two** Less serious condition. Requires emergency medical attention.
- Three** Non-emergent condition. Requires medical attention but not on an emergency basis.
- Four** Does not require medical attention and may not require transport.
- N/A** Priority assessment does not apply to this call (for example, no patient).

SECTION 6: PATIENT DEMOGRAPHICS

Record the age, race, and gender of your patient in the Patient Demographics, Section 6.

PT. AGE
<input type="radio"/> M <input type="radio"/> D
<input type="radio"/> 0 <input type="radio"/> 0 <input checked="" type="radio"/> 1 <input type="radio"/> 1 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 9

AGE

If your patient is **between 2 and 11 months old**, you should mark the **M** response as well as responses for the appropriate number of months. Patients **between the ages of 1 and 31 days old** should have the **D** response marked along with the appropriate number of days. Leave the **M** and **D** responses **blank for patients one year of age or older**, and darken the responses corresponding to their age in years.

RACE/ETHNICITY

RACE Hispanic or Latino? <input type="radio"/> Y <input type="radio"/> N	Mark all that apply	<input type="radio"/> American Indian or Alaska Native	<input type="radio"/> Asian	<input type="radio"/> Black or African American
		<input type="radio"/> Native Hawaiian or Other Pacific Islander	<input type="radio"/> White	

The Annotated Code of Maryland, requires that any state agency requiring use of a form which identifies individuals by race, shall include instructions that multi-racial respondents may select all applicable racial categories. Respondents shall select their own answers, except when it is not possible for the respondent to do so. A form that requires identification of individuals by race shall include a separate question about whether a respondent is of Hispanic or Latino origin, with the question preceding the racial category question.

GENDER

G E N D E R
<input type="radio"/> M
<input type="radio"/> F

Mark the response that corresponds to your patient's gender.

SECTION 7: VITAL SIGNS, GLUCOSE MONITORING, LOSS OF CONSCIOUSNESS, LUNG SOUNDS, GLASGOW COMA SCORE, SAFETY EQUIPMENT USE, TRAUMA IDENTIFIERS, MECHANISMS OF INJURY

FIRST VITALS			
SYS	DIA	PUL	RES
<input type="radio"/> 0	<input type="radio"/> 0 <input type="radio"/> P	<input type="radio"/> 0	<input type="radio"/> 0
<input type="radio"/> 100	<input type="radio"/> 100	<input type="radio"/> 100	<input type="radio"/> 100
<input type="radio"/> 200	<input type="radio"/> 200	<input type="radio"/> 200	<input type="radio"/> 200
<input type="radio"/> 10 <input type="radio"/> 1	<input type="radio"/> 10 <input type="radio"/> 1	<input type="radio"/> 10 <input type="radio"/> 1	<input type="radio"/> 10 <input type="radio"/> 1
<input type="radio"/> 20 <input type="radio"/> 2	<input type="radio"/> 20 <input type="radio"/> 2	<input type="radio"/> 20 <input type="radio"/> 2	<input type="radio"/> 20 <input type="radio"/> 2
<input type="radio"/> 30 <input type="radio"/> 3	<input type="radio"/> 30 <input type="radio"/> 3	<input type="radio"/> 30 <input type="radio"/> 3	<input type="radio"/> 30 <input type="radio"/> 3
<input type="radio"/> 40 <input type="radio"/> 4	<input type="radio"/> 40 <input type="radio"/> 4	<input type="radio"/> 40 <input type="radio"/> 4	<input type="radio"/> 40 <input type="radio"/> 4
<input type="radio"/> 50 <input type="radio"/> 5	<input type="radio"/> 50 <input type="radio"/> 5	<input type="radio"/> 50 <input type="radio"/> 5	<input type="radio"/> 50 <input type="radio"/> 5
<input type="radio"/> 60 <input type="radio"/> 6	<input type="radio"/> 60 <input type="radio"/> 6	<input type="radio"/> 60 <input type="radio"/> 6	<input type="radio"/> 60 <input type="radio"/> 6
<input type="radio"/> 70 <input type="radio"/> 7	<input type="radio"/> 70 <input type="radio"/> 7	<input type="radio"/> 70 <input type="radio"/> 7	<input type="radio"/> 70 <input type="radio"/> 7
<input type="radio"/> 80 <input type="radio"/> 8	<input type="radio"/> 80 <input type="radio"/> 8	<input type="radio"/> 80 <input type="radio"/> 8	<input type="radio"/> 80 <input type="radio"/> 8
<input type="radio"/> 90 <input type="radio"/> 9	<input type="radio"/> 90 <input type="radio"/> 9	<input type="radio"/> 90 <input type="radio"/> 9	<input type="radio"/> 90 <input type="radio"/> 9

VITAL SIGNS

Record the first set of vital signs based on the findings of your primary assessment of your patient. Vital signs are recorded using combinations of responses for hundreds (100, 200), tens (10 - 90), and units (1 - 9). A systolic pressure of 216 would have the responses for 200, 10, and 6 filled in. All vital signs are recorded in the same manner.

Use the 0 (zero) responses only for patients who were monitored and found to have no vital signs. **Do NOT mark zero** responses for patients whose vital signs are unobtainable.

The "P" response in the Diastolic blood pressure section should be marked to record that a blood pressure was taken by palpation.

<input type="radio"/> Glucometer

GLUCOSE MONITORING

Darken the Glucometer response if you monitor blood glucose. You should note the blood glucose value in the boxes provided in the lower right corner of the form.

LOC PTA
<input type="radio"/> Y <input type="radio"/> N

LOSS OF CONSCIOUSNESS PRIOR TO ARRIVAL

Mark **Yes** if there are signs or testimony that your patient was unconscious prior to the arrival of your unit. Mark **No** if there were no indications of loss of consciousness.

LUNGS	
Normal	<input type="radio"/> L <input type="radio"/> R
Wheeze	<input type="radio"/> L <input type="radio"/> R
Rales	<input type="radio"/> L <input type="radio"/> R
Rhonchi	<input type="radio"/> L <input type="radio"/> R

LUNG SOUNDS

Mark the **Normal** response(s) for **Right** and/or **Left** lung(s) if your primary assessment found equal, clear breath sounds.

Mark the **Wheeze** response(s) for **Right** and/or **Left** lung(s) if your primary assessment found whistling type breath sounds associated with narrowing or spasm of the smaller airways.

Mark the **Rales** responses(s) for **Right** and/or **Left** lung(s) if your primary assessment found abnormal breath sounds due to the presence of fluid in the smaller airways.

Mark the **Rhonchi** response(s) for **Right** and/or **Left** lung(s) if your primary assessment found abnormal breath sounds due to the presence of fluid or mucous in the larger airways.

GCS		
E	M	V
<input type="radio"/> 1	<input type="radio"/> 1	<input type="radio"/> 1
<input type="radio"/> 2	<input type="radio"/> 2	<input type="radio"/> 2
<input type="radio"/> 3	<input type="radio"/> 3	<input type="radio"/> 3
<input type="radio"/> 4	<input type="radio"/> 4	<input type="radio"/> 4
	<input type="radio"/> 5	<input type="radio"/> 5
	<input type="radio"/> 6	

GLASGOW COMA SCORE

Mark the appropriate responses for Glasgow Coma Score **eye, motor, and verbal** responses. Verbal responses should be determined **based on the patient's age**. See the reverse side of the MAIS form for Glasgow Coma Score response definitions.

SAFETY EQUIPMENT USED		
<input type="radio"/> Safety Seat	<input type="radio"/> Airbag	<input type="radio"/> Helmet
	<input type="radio"/> Belt/Harn	<input type="radio"/> None

SAFETY EQUIPMENT USED

Document the use or non-use of **safety equipment** by your patient if applicable. **Mark all responses that apply.**

TRAUMA ID	
<input type="radio"/> Shock	<input type="radio"/> CNS Injury
<input type="radio"/> Multi Sys	<input type="radio"/> Mechanism
<input type="radio"/> Severe S Sys	<input type="radio"/> Other Fatal
<input type="radio"/> Pen Wnd	<input type="radio"/> Age

TRAUMA IDENTIFIER(S)

Document the **trauma identifier(s)** that apply to your patient. Trauma identifier data should be reported for all serious injury patients independent of transportation to a designated specialty center. **Mark all responses that apply.**

MECHANISMS		
<input type="radio"/> Deformity	<input type="radio"/> Entrap	<input type="radio"/> Speed
<input type="radio"/> Ejection	<input type="radio"/> Fall > 3 X Height	

MECHANISM(S) OF INJURY

Report all factors associated with your patient's injuries that may warrant special consideration. **Trauma mechanism(s)** data should be documented for all serious injury patients independent of transportation to a designated specialty center. **Mark all responses that apply.**

SECTION 8: SIGNS AND SYMPTOMS, INJURY TYPES, CONDITIONS, CARDIAC ARRHYTHMIAS, CIRCULATION

Section 8 includes a broad range of assessment information related to your patient's current need for pre-hospital care.

SIGNS/SYMPTOMS	INJURY TYPE	CONDITIONS	ECG
<input type="checkbox"/> Agitated	<input type="checkbox"/> ATV Crash	<input type="checkbox"/> Allergic Rxn	<input type="checkbox"/> <input type="checkbox"/> Nor Sinus
<input type="checkbox"/> Airway Obs	<input type="checkbox"/> Beating	<input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Sinus Tach
<input type="checkbox"/> Cyanotic	<input type="checkbox"/> Bike	<input type="checkbox"/> Behavioral	<input type="checkbox"/> <input type="checkbox"/> A-Fib
<input type="checkbox"/> Dehydrated	<input type="checkbox"/> Burn	<input type="checkbox"/> Cardiac Arst	<input type="checkbox"/> <input type="checkbox"/> SVT
<input type="checkbox"/> Diaphoretic	<input type="checkbox"/> Drowning	<input type="checkbox"/> CHF	<input type="checkbox"/> <input type="checkbox"/> Sinus Brad
<input type="checkbox"/> Hemorrhage	<input type="checkbox"/> Fall	<input type="checkbox"/> COPD	<input type="checkbox"/> <input type="checkbox"/> Block <i>degree</i>
<input type="checkbox"/> Hypothermic	<input type="checkbox"/> Farm	<input type="checkbox"/> CVA	<input type="checkbox"/> <input type="checkbox"/> Asystole ①
<input type="checkbox"/> Laceration	<input type="checkbox"/> GSW	<input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> PEA ②
<input type="checkbox"/> Nausea	<input type="checkbox"/> Industrial	<input type="checkbox"/> DNR <input type="checkbox"/> A	<input type="checkbox"/> <input type="checkbox"/> PVC'S ③
<input type="checkbox"/> Head <input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lawn Mwr	<input type="checkbox"/> Environmental	<input type="checkbox"/> <input type="checkbox"/> Vent Fib
<input type="checkbox"/> Neck <input type="checkbox"/> Abdm	<input type="checkbox"/> Motorcycle	<input type="checkbox"/> GI Disorder	<input type="checkbox"/> <input type="checkbox"/> Vent Tach
<input type="checkbox"/> Back <input type="checkbox"/> Extrm	<input type="checkbox"/> M V Crash	<input type="checkbox"/> Med. Illness	<input type="checkbox"/> <input type="checkbox"/> Other
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Pedestrian	<input type="checkbox"/> MI/Cardiac	<input type="checkbox"/> 3 Lead <input type="checkbox"/> 12 Lead
<input checked="" type="checkbox"/> Pupils <input type="checkbox"/> A	<input type="checkbox"/> Sport/Rec	<input type="checkbox"/> OB/GYN	CIRCULATION
<input type="checkbox"/> Resp Distrs	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Overdose	PROV#
<input type="checkbox"/> Syncope	<input type="checkbox"/> Toxic Inhal	<input type="checkbox"/> Poison	IV1 <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Venom Bite	<input type="checkbox"/> Resp Arst	IV2 <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
<input type="checkbox"/> Weakness	<input type="checkbox"/> Other	<input type="checkbox"/> Seizures	EJ <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
<input type="checkbox"/> Other		<input type="checkbox"/> Other	IO <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

SIGNS AND SYMPTOMS

Report **signs and symptoms** related to your patient's current condition in this section. Note that some signs and symptoms relate to both injury and medical patients. **Mark all responses that apply.** If your patient experienced **signs or symptoms** other than those listed, you should mark the **"Other"** response and note the **signs or symptoms** in the blank space provided at the bottom of the form.

INJURY TYPES

Use the **injury type** section to report causes of injuries experienced by your patient. **Mark all responses that apply.** If you need to document an injury type other than those listed, mark the **"Other"** response and note the **other injury type** in the blank space provided at the bottom of the form.

CONDITIONS

Mark the **illness(es) or medical condition(s)** contributing to your patient's **current need** for pre-hospital care. **Mark all responses that apply.** To document a condition other than those listed, mark the **"Other"** response and note the **other condition** in the blank space provided at the bottom of the form. For an explanation of documentation for **DNR (Do Not Resuscitate)** orders see Addendum # 1.

NOTE: In the Conditions section, the response previously labeled Exposure has been changed to Environmental.

E.C.G.

Document your patient's first (F) and last (L) electrocardiogram rhythms. If you need to document a cardiac rhythm other than those listed, mark the **"Other"** response and provide a description in the blank space provided at the bottom of the form. Document whether a three lead or twelve lead ECG was used by marking the appropriate response.

CIRCULATION

IV 1 Attempt Mark this response (A) if the first or second attempt at establishing the **first intravenous line** was unsuccessful.

IV 1 Success Mark the (S) response if the **first intravenous line was successfully established**.

Use the 1, 2, and 3 responses to indicate which providers were responsible for the first intravenous line attempts or success. If two providers attempted to establish the first line and neither was successful, mark both provider numbers.

If two providers attempted and only one was successful, mark only the number identifying the successful provider.

IV 2 Attempt Mark this response (A) if the first or second attempt at establishing the **second intravenous line** was unsuccessful.

IV 2 Success Mark the (S) response if the **second intravenous line was successfully established**.

Use the 1, 2, and 3 responses to indicate which providers were responsible for the second intravenous line attempts or success. If two providers attempted to establish the second line and neither was successful, mark both provider numbers.

If two providers attempted and only one was successful, mark only the number identifying the successful provider.

EJ (External Jugular) Attempt Mark the (A) response if external jugular placement was **attempted, but not successful**, for either the first or second intravenous fluid line.

EJ (External Jugular) Success Mark the (S) response if external jugular placement was **attempted and successful** for either the first or second intravenous fluid line.

Use the 1, 2, or 3 responses to document which provider was responsible for the external jugular IV attempt or success.

If two providers attempted and only one was successful, mark only the number identifying the successful provider.

IO (Intraosseous) Attempt Mark the (A) response if intraosseous intravenous fluid line placement was **attempted, but not successful**, for either the first or second intravenous fluid line.

IO (Intraosseous) Success Mark the (S) response if intraosseous placement of an intravenous fluid line was attempted and successful for either the first or second intravenous fluid line.

Use the 1, 2, or 3 responses to document which provider was responsible for the intravenous IV attempt or success.

If two providers attempted and only one was successful, mark only the number identifying the successful provider.

Record the amount (**total CC's**) of intravenous fluids infused during pre hospital care in the boxes provided on the lower right corner of the form.

Record the anatomical site and needle gauge used in IV placement on the line provided at the bottom of the form.

SECTION 9: CARDIAC ARREST WITNESSED, CPR STARTED BY, AED STARTED BY, RETURN OF SPONTANEOUS CIRCULATION AT E.D.

CARDIAC ARREST WITNESSED

C/A WITNESSED	
<input type="radio"/> Yes	<input type="radio"/> No

Mark **Yes** if the signs and/or symptoms of cardiac arrest were witnessed at the onset. Mark **No** if the signs and/or symptoms of cardiac arrest **were not** witnessed at onset.

CPR START BY

CPR START BY	
<input type="radio"/> Citizen	<input type="radio"/> BLS
<input type="radio"/> 1st Resp	<input type="radio"/> ALS

If **CPR is initiated**, identify the EMS training level of the individual providing care. In cases where multiple individuals administered CPR procedures, record the training level of the highest certified individual. You should note the time CPR was initiated in the blank space provided at the bottom of the form.

AED START BY

AED START BY	
<input type="radio"/> Citizen	
<input type="radio"/> 1st Resp	
<input type="radio"/> BLS	
<input type="radio"/> ALS	

If use of an AED is initiated, identify the EMS training level of the individual providing care. In cases where multiple individuals administered AED procedures, record the training level of the highest certified individual. You should note the time AED use was initiated in the blank space provided at the bottom of the form.

RETURN of SPONTANEOUS CIRCULATION at E. D.

ROSC at ED	
<input type="radio"/> Yes	<input type="radio"/> No

Darken the Yes response if the patient did experience return of spontaneous circulation prior to arrival at an emergency department. If the patient did not experience return of spontaneous circulation prior to arrive at an emergency department, darken the No response.

SECTION 10: AIRWAY/VENTILATION, PROCEDURES, OTHER CARE RENDERED

AIRWAY/VENTILATION

AIRWAY/VENTILATION	
<input type="radio"/> Suction	<input type="radio"/> Orophar
<input type="radio"/> Nasophar	<input type="radio"/> Face Mask
<input type="radio"/> N C	<input type="radio"/> PPD
<input type="radio"/> NR Mask	<input type="radio"/> Pulse Ox
<input type="radio"/> BVM	<input type="radio"/> O ₂
<input type="radio"/> Mech Vent	<input type="radio"/> CPAP
<input type="radio"/> Hypervent.	<input type="radio"/> Other

Document all of the **airway/ventilation equipment or procedures** attempted. You should write the number of **liters per minute** at which oxygen was administered in the boxes provided on the lower right corner of the form.

If you use procedures or equipment other than those listed, mark the "Other" response and note the procedure or equipment used in the blank space provided at the bottom of the form.

PROCEDURES									
	ET	NT	NG	NDT	DEFIB	AED	CARDIO	PACE	COMBI
PROV #	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)	(S)
	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)
	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)

PROCEDURES

Identify attempts and successes for other types of prehospital procedures.
You should also identify the providers performing each procedure.

- ET (A)** Endotracheal tube placement was **attempted, but was not successful.**
ET (S) Endotracheal tube placement was **attempted and successful.**
PROV # Document the providers responsible for **ET** attempt or success.
- ET Size** Record the size of the endotracheal tube used in the boxes provided on the lower right corner of the form.
- NT (A)** Nasotracheal tube placement was **attempted, but was not successful.**
NT (S) Nasotracheal tube placement was **attempted and successful.**
PROV # Document the providers responsible for **NT** attempt or success.
- NG (A)** Nasogastric tube placement was **attempted, but was not successful.**
NG (S) Nasogastric tube placement was **attempted and successful.**
PROV # Document the providers responsible for **NG** attempt or success.
- NDT (A)** Needle Decompression Thoracostomy was **attempted, but was not successful.**
NDT (S) Needle Decompression Thoracostomy was **attempted and successful.**
PROV # Document the providers responsible for **NDT** attempt or success.
- DEFIB (A)** Defibrillation was **attempted, no change in rhythm.**
DEFIB (S) Defibrillation was **attempted with change to viable rhythm.**
PROV # Document the providers responsible for **DEFIB** attempt or success.
- AED (A)** Automated External Defibrillation was **attempted, no return to normal rhythm.**
AED (S) Automated External Defibrillation was **attempted with return to normal rhythm.**
PROV # Document the providers responsible for **AED** attempt or success.
- CARDIO (A)** Cardioversion was **attempted, no return to normal rhythm.**
CARDIO (S) Cardioversion was **attempted with change from tachycardia to normal rhythm.**
PROV # Document the providers responsible for **CARDIO** attempt or success.
- PACE (A)** External Pacing was **attempted, no capture of rhythm or pulse.**
PACE (S) External Pacing was **attempted with capture of rhythm AND pulse.**
PROV # Document the providers responsible for **PACE** attempt or success.
- COMBI (A)** Intubation using a **Combitube** was attempted.
COMBI (S) Intubation by **Combitube** was successful.
PROV # Document the providers responsible for **COMBITUBE** attempt or success.

OTHER CARE	
CPR	<input type="radio"/>
CPR Mech	<input type="radio"/>
Cntrl Bld	<input type="radio"/>
OB Delivery	<input type="radio"/>
Other Care	<input type="radio"/>
PASG	<input type="radio"/>
Restraint	<input checked="" type="radio"/> (C) <input checked="" type="radio"/> (P)
Spinal Imm	<input type="radio"/>
Tract/Splnt	<input type="radio"/>

OTHER CARE RENDERED

Document all care rendered to your patient. If you provide care other than the types listed, mark the "Other" response and note the type of care in the blank space provided at the bottom of the form. **Note that the use of restraints is now identified by the type of restraint: 'C' for chemical, 'P' for physical.**

SECTION 11: MEDICATIONS

Document all of the medications administered to your patient. If your certification level is EMT-B and you assist with medications, you should mark the "Assist Meds" response that corresponds to your provider number in addition to the medication you have assisted with.

MEDS	P1	P2	P3	MEDS	P1	P2	P3
Adenosine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Furosemide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Albuterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glucagon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glucose Paste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assist Meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Haloperidol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atropine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ipecac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benadryl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ipratropium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benzocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lidocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calcium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lidocaine Gel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Charcoal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MARK I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dextrose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Midazolam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diazepam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morphine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diltiazem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Na Bicarb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dopamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Naloxone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epi 1:10 K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epi 1:1 K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Saline Nebulizer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epi Nebulizer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Succinylcholine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EpiPen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Terbutaline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Factor VIII or IX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vecuronium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Providers administering medications should have the responses corresponding to their Provider ID numbers (1, 2, or 3 from Section 1) marked for each medication they administer.

The following medications have been deleted:
Droperidol, Heparin

The following medications have been added:
Haloperidol, Ipratropium, MARK I Kit, Saline Nebulizer.

SECTION 12: HOSPITAL CODES

HOSPITALS								
Consulting			Transferring			Receiving		
<input type="checkbox"/> 0	<input type="checkbox"/> 0	<input type="checkbox"/> 0	<input type="checkbox"/> 0	<input type="checkbox"/> 0	<input type="checkbox"/> 0	<input type="checkbox"/> 0	<input type="checkbox"/> 0	<input type="checkbox"/> 0
<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 1
<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2	<input type="checkbox"/> 2
<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 3
<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4	<input type="checkbox"/> 4
<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5	<input type="checkbox"/> 5
<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6	<input type="checkbox"/> 6
<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7	<input type="checkbox"/> 7
<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8	<input type="checkbox"/> 8
<input type="checkbox"/> 9	<input type="checkbox"/> 9	<input type="checkbox"/> 9	<input type="checkbox"/> 9	<input type="checkbox"/> 9	<input type="checkbox"/> 9	<input type="checkbox"/> 9	<input type="checkbox"/> 9	<input type="checkbox"/> 9

Darken the hospital code numbers (from Appendix A) that correspond to the consulting, transferring, and receiving hospitals for this call.

If this call requires consultation with a hospital, darken the responses that correspond to the consulting hospital's code number in the **Consulting** section.

If this call is an inter-hospital transfer, you should darken the responses that correspond to the transferring hospital's code in the **Transferring** section.

Mark the responses that correspond to the receiving hospital's code in the **Receiving** section.

SECTION 13: TRANSPORTATION/COMMUNICATION/SPECIAL PURPOSE

TRANSPORT BY

Mark only **one** response in the **Transport By** section.

TRANSPORT BY	
<input type="radio"/>	No Transport
<input type="radio"/>	This Unit
<input type="radio"/>	Other Unit
<input type="radio"/>	Other Air

Mark **No Transport** if your current call resulted in no patient transport.

Mark **This Unit** if the patient was transported by your unit..

Mark **Other Unit** if the patient was transported by another ground unit.

Mark **Other Air** if the patient was transported by helicopter.

REASON HOSPITAL CHOSEN	
<input type="radio"/> Closest	<input type="radio"/> Inter-facil trnsfr
<input type="radio"/> Spec Ref	<input type="radio"/> Patient Choice
<input type="radio"/> Rerte-Alert	<input type="radio"/> Routine Trnsprt
<input type="radio"/> Rerte-Consult	<input type="radio"/> Stroke Care

REASON HOSPITAL CHOSEN

Document the reason a particular receiving facility was chosen for this patient.

Closest

Protocols and conditions allowed transport to closest hospital.

Spec Ref

Patient required the services of a specialty referral center. These include designated centers for:

Perinatal Complications

Hand/Extremity Injuries/Reimplantation

Neurotrauma

Adult Trauma

Burn Trauma

Neonatal Complications

Hyperbaric Medicine

Pediatric Trauma

Eye Trauma

Rerte-Alert

Patient transport was rerouted because the closest hospital was on alert.

Rerte-Consult

Patient transport was rerouted because of physician consult doing transport.

Inter-facil Trnsfr

Patient transfer from one facility to another.

Routine

Non-emergent transport according to departmental regulations.

Patient

Patient or guardian specified receiving hospital.

Stroke Care

Identifies patients transported to a particular facility based on Stroke protocol.

RADIO
<input type="radio"/> No Attempt
<input type="radio"/> Poor
<input type="radio"/> Good
<input type="radio"/> Failed

RADIO

Document the quality of the EMS radio communications for this call.

No Attempt

This call did not require radio communication.

Good

All communications were discernible.

Poor

Some communications were not discernible and required repeated transmissions beyond normal expectations.

Failed

Radio communications failed to permit proper or complete transmission of information.

SPECIAL PURPOSE	
<input type="radio"/> Multi Pats Seen	<input type="radio"/> Hazmat Call
<input type="radio"/> Multi Pats Trans	<input type="radio"/> Addit Narr
<input type="radio"/> Exceptional Call	
<input type="radio"/> Fire Rehab	

SPECIAL PURPOSE

Mul Pat Seen

Two or more patients were assessed/treated on this call regardless of whether anyone was transported.

Mul Pat Trans

Two or more patients were transported from this incident.

Haz Mat

Hazardous materials protocols were required in response to this call.

Fire Rehab

Identifies this call as EMS activity related to a working fire.

Add Nar

Indicates an additional narrative form was completed for this patient.

Excep Call

Documents call which fall outside the normal standard of performance.

VAR (A) (B) (C) (D) (E) (1) (2) (3) (4) (5) (6) (7) (8) (9)

VAR

The five **alphabetic** (A through E) responses are available for jurisdictional use and may be used to collect data for short-term research or jurisdictionally defined data needs. The **numeric** (1 through 9) responses are reserved for use as designated by MIEMSS. **Response number four (4) should be used to identify First Responder units arriving at an incident scene prior to the arrival of a medic unit.**

SECTION 14: PROVIDER EXPOSURE, DOCUMENTATION OF CARE RENDERED, NARRATIVE INFORMATION, AND FORM IDENTIFICATION

Use Section 14 to document provider exposures and patient care provided. Space is provided for two distinct patient care entries. Additional blank space is provided at the bottom of the form for narrative documentation of your call.

PROV. EXP ☐ NS ☐ B ☐ A ☐ O

PROVIDER EXPOSURE

Document any exposure to a potentially infectious agent by marking the appropriate responses. Mark as many responses as are applicable.

Mark the **NS (needle stick)** response if any member of the crew on this unit experienced a needle stick.

Mark the **B (blood)** response for exposures to blood or any body fluid. This applies to both mucous or percutaneous exposures. For example, if blood splashed in the eye, nose, or on broken skin, mark this response.

Mark the **A (airborne)** response for exposure to airborne pathogens. If your patient coughed, or sneezed in close proximity to any member of the crew on your unit, or if the patient exhibited other signs of respiratory illness, mark this response.

Mark the **O (other)** response for exposure to other body fluids such as vomitus, urine, stool, CSF, etc.

You should document specifics of any exposure in the narrative section of this report before leaving the receiving facility.

DOCUMENTATION OF CARE RENDERED

SaO ₂			ET SIZE		O ₂ LPM		TOTAL cc's			GLUCOSE		Gauge Site: _____
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	MILEAGE: _____	
On-line Physician: _____						Provider Signature: _____						
Hospital Signature: _____						EMS Reviewer: _____						
PROV #	TIME	BP	PUL	RESP	RHYTHM	CARE PROVIDED	AMOUNT					
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					

Space has been provided at the bottom of the form to document the following information based on the care rendered to your patient:

SAO₂ Record the patient's saturated oxygen value based on Pulse Oximetry in the boxes provided.

ET size Record the Endotracheal tube size if you intubated the patient.

O₂ lpm Record the liters per minute of oxygen administered to the patient.

Total cc's	Record the amount of intravenous fluids infused during prehospital care in the boxes provided.
Glucose	If you monitored the patient's blood glucose with a glucometer, you should record the glucose level in the boxes provided.
Gauge/Site	Record the anatomical site(s) and needle gauge used for IV placement.
Mileage	Record the number of miles driven for this call.
On-line Physician	Record the name of the physician who provided medical direction during radio consult.
Provider Signature	The provider considered to be the medically responsible provider among the crew should sign on the provider signature line.
Hospital Signature	Obtain the signature of an authorized hospital employee at the time you deliver your patient to the receiving facility. Protocols stipulate that the employee receiving the patient must be at least the same or higher level of training as the highest certified provider on the unit.
EMS Reviewer	The name of the individual reviewing the contents of the form should be recorded on the EMS reviewer line.
PROV #	Documents which provider (1, 2, or 3) was responsible for the provision of care reported in this entry.
TIME	Military time corresponding to the time care was provided.
B.P.	Blood pressure at the time care was given.
Pulse	Record the pulse at the time care was given.
Resp	Respirations at the time care was given.
Rhythm	Rhythm from E.C.G. reading, if applicable.
Care Provided	Document other care such as administering medications here.
Amount	Use this space to document amounts of meds administered, etc.

NARRATIVE INFORMATION

Space has been provided to document pertinent information about your call. If you require additional space, please complete an additional narrative form. **BE CERTAIN NOT TO EXTEND HAND WRITTEN INFORMATION INTO THE SCANNABLE PORTIONS OF THE FORM. THE SLIGHTEST STRAY MARK IN ONE OF THE RESPONSE AREAS MAY BE INTERPRETED AS A VALID MARK.**

FORM IDENTIFICATION

MIEMSS RECORD OFFICIAL COPY

The top copy is the scannable document to be submitted to MIEMSS.
Is the legal copy of the record and should be retained at the
jurisdiction/company level.

HOSPITAL COPY

Is the copy to be left at the receiving facility.

Addendum 1
Documentation of EMS/DNR Orders

Emergency Medical Services Personnel who respond and find, or are presented with, an apparently valid EMS/DNR Order should document the EMS/DNR patient care option indicated by the Patient or the Patient's Authorized Decision Maker or Signatory as follows:

If Option A, "Maximal (Restorative) Care Before Arrest, Then DNR" has been selected on the EMS/DNR Order, the "A" response to the right of the DNR label on the MAIS form should be darkened. If Option B, "Limited (Palliative) Care Only Before Arrest, Then DNR" was selected on the EMS/DNR Order, the "B" response to the left of the DNR label on the MAIS form should be darkened. Older versions of EMS/DNR Orders continue to be valid and should be documented on the MAIS form with a "B" response, as Option B, "Limited (Palliative) Care Only Before Arrest, Then DNR".

Upon request of the patient, family, or caregiver and in lieu of transport to a hospital based emergency department, EMS providers may transport an Option B EMS/DNR patient directly to an in-patient hospice facility. Hospital code numbers for approved hospice in-patient facilities meeting the requirements of Sections 6.2.1 and 6.2.4 of the Maryland EMS/DNR Protocol are as follows:

Hospice of Baltimore – Gilchrist Center 6601 North Charles Street Baltimore, MD 21204	Code # 450
Joseph Richey Hospice – Joseph Richey House 828 N. Eutaw Street Baltimore, MD 21201	Code # 451
Stella Maris Hospice 2300 Dulaney Valley Road Timonium, MD 21202	Code # 452
Stella Maris Hospice at Mercy Hospital 301 St. Paul Place, 8th Floor Baltimore, Md 21202	Code # 453

Appendix A
Hospital Codes

345	10th Street Medical Center, Ocean City, MD
409	126th Street Medical Center, Ocean City, MD
346	26th Street Medical Center, Ocean City, MD
379	63rd Street Medical Center, Ocean City, MD
380	75th Street Medical Center, Ocean City, MD
347	93rd Street Medical Center, Ocean City, MD
230	Alexandria Hospital, VA
751	Alfred I. DuPont Hospital for Children (formerly listed as Alfred I DuPont Institute)
422	Alleghany General Hospital, Alleghany, PA
397	Altoona Rehabilitation Hospital
231	Andrew Rader Clinic, VA
221	Anne Arundel General Hospital
382	Anne Arundel Medical Park
550	Annie M. Warner Hospital
233	Arlington Hospital, VA
381	Atlantic General Hospital
520	Baltimore City Public Service Infirmary
350	Bayhealth Medical Center, Kent Hospital (formerly listed as Kent General)
359	Bayhealth Medical Center, Milford Hospital (formerly listed as Milford Memorial Hospital)
551	Bedford County Memorial Hospital, PA
358	Beebe Medical Center (formerly listed as Beebe Hospital of Sussex County)
234	Beebe Medical Center, Millville Center (formerly listed as Bethany Emergency Center)
355	Bethesda Naval Hospital / National Capital Region Naval Medical Command
208	Bon Secours Hospital
353	Bowie Health Center
235	Brooke Lane Psychiatric Center
236	Brunswick Medical Center
553	Bryn Mawr Hospital
752	Bryn Mawr Rehabilitation Hospital
754	Bryn Mawr Rehabilitation Hospital at Maryland General Hospital
771	Calvert County Nursing Home Center
266	Calvert Memorial Hospital
237	Capitol Hill Hospital, DC
554	Carlisle Hospital
555	Carpenter's Clinic
219	Carroll County General Hospital
238	Carter Community Mental Health & Retardation Center
755	Central Industrial Medical Center
276	Chambersburg Hospital, PA
284	Charlestown Area Medical Center
241	Chemtrec Chem Mfgs Assn Chemical Transportation Emergency Center, Wash., D.C.
243	Chestnut Lodge Hospital
419	Children's Hospital – Hershey Medical Center - Hershey, PA.
225	Children's Hospital & Center for Reconstructive Surgery - Baltimore, MD
756	Children's Hospital of Pennsylvania
818	Children's National Medical Center Neonatal Center - Wash., D.C. (formerly Children's Hosp. National Medical Center Neonatal Center - D.C.)
718	Children's National Medical Center Pediatric Burn Center (formerly Children's Hosp. National Medical Center Ped. Burn Center - D.C.)
717	Children's National Medical Center Pediatric Trauma Center (formerly Children's Hosp. National Medical Center Ped. Trauma Center)
317	Children's National Medical Center, D.C. (formerly listed as Children's Hospital National Medical Center, D.C.)
304	Christiana Care Health Systems, Christiana Hospital (formerly listed as Christiana Hospital)
299	Christiana Care Health Systems, Wilmington Hospital (formerly listed as Wilmington Hospital)
202	Church Hospital
341	City Hospital, Martinsburg, WV
291	Civista, (formerly listed as Physicians Memorial Hospital)
245	Columbia Hospital for Women Medical Center, Washington, D.C.
383	Columbia Medical Plan
757	Cooper Trauma Center, N.J.
248	Crownsville State Hospital
252	Cullen Center
342	DC General Hospital
842	DC General Hospital Neonatal Center
254	Deaton Hospital & Medical Center of Christ Lutheran Church

Appendix A
Hospital Codes

293	Deer's Head State Hospital
556	Delaware Memorial Hospital, DE
256	DeWitt Army Hospital, VA
329	Doctor's Community Hospital (formerly listed as Doctor's Hospital of Prince George's County (AMI Doctor's))
257	Dominion Hospital, VA
310	Dover U.S. Air Force Clinic (formerly listed as Dover U.S. Air Force Hospital)
302	DuPont Memorial Hospital
421	Eastern Neurological Rehabilitation Hospital
331	Eastern Shore State Hospital
557	Elizabethtown Children's Hospital
306	Ellsmere Veteran's Administration Hospital, DE
558	Emmitsburg Hospital
340	Fair Oaks Hospital (formerly listed as Commonwealth Hospital), VA
305	Fairfax Hospital, VA
224	Upper Chesapeake Health System (formerly listed as Fallston General Hospital)
258	Finan Center State Psychiatric Facility
279	Fort Dietrick Medical Center
247	Fort Howard Veteran's Administration Hospital
522	Fort Washington Hospital
203	Franklin Square Hospital
239	Frederick Memorial Hospital
253	Freeman Hospital
319	Frostburg Hospital
286	Fulton County Medical Center, PA
322	Garrett County Memorial Hospital
580	Geisinger Medical Center, PA
335	George Washington University Hospital, DC
737	Georgetown University Hospital Eye Trauma Center, DC
337	Georgetown University Hospital, DC
240	Gettysburg Hospital, PA
759	Gladys Spellman Nursing Center
226	Good Samaritan Hospital of Maryland
559	Grant Memorial Hospital
217	Greater Baltimore Medical Center
817	Greater Baltimore Medical Center Neonatal Center
261	Greater Northeast Medical Center, DC (see also Northeast Georgetown #313)
316	Greater Southeast Community Hospital, DC
348	Groupe Memorial Hospital
263	Gundry Hospital
363	Hadley Memorial Hospital, DC
560	Hagerstown State Hospital
561	Hampshire Memorial Hospital, WV
242	Hanover General Hospital, PA
211	Harbor Hospital Center (formerly listed as South Baltimore General Hospital)
220	Harford Memorial Hospital
562	Harryon State Hospital
399	Health South Chesapeake Rehabilitation Center (formerly listed as Chesapeake Rehabilitation Hospital)
420	Health South Rehabilitation Hospital of Altoona
267	Highland State Health Facility Psychiatric Unit
244	Holy Cross Hospital of Silver Spring
450	Hospice of Baltimore - Gilchrist Center - Baltimore, MD
268	Hospital for Sick Children, DC
223	Howard County General Hospital
270	Howard University Hospital, DC
349	Isle of Wight Medical Center
273	Jefferson Memorial Hospital, Arlington, VA
314	Jefferson Memorial Hospital, Ranson, WV
601	Johns Hopkins Bayview Adult Trauma Center
701	Johns Hopkins Bayview Burn Unit
201	Johns Hopkins Bayview Medical Center
801	Johns Hopkins Bayview Neonatal Center

Appendix A
Hospital Codes

901	Johns Hopkins Bayview Perinatal Center
761	Johns Hopkins Comprehensive Geriatric Center
766	Johns Hopkins Bayview Medical Center Transitional Care Unit
204	Johns Hopkins Hospital
604	Johns Hopkins Hospital Adult Trauma Center
705	Johns Hopkins Hospital Eye Trauma Center
706	Johns Hopkins Hospital Inpatient Rehabilitation Center
804	Johns Hopkins Hospital Neonatal Intensive Care Unit
704	Johns Hopkins Hospital Pediatric Trauma Center
904	Johns Hopkins Hospital Perinatal Center
451	Joseph Richey Hospice - Joseph Richey House, Baltimore, MD
274	Kennedy-Krieger Institute (formerly listed as John F. Kennedy Institute for Handicapped Children)
296	Kent and Queen Anne's Hospital
227	Kernan Hospital
277	Keswick Home for the Incurables of Baltimore City
262	Kimbrough Army Hospital
563	Kings Daughters Hospital, WV
259	Kirk Army Hospital
403	Lancaster General Hospital, PA
564	Lancaster Osteopathic Hospital, PA
773	Laurel Regional Hospital – Rehabilitation
352	Laurel Regional Hospital (formerly listed as Greater Laurel Beltsville Hospital)
565	Leesburg Hospital, VA
251	Leland Memorial Hospital (closed per Region V Office)
278	Levindale Hebrew Geriatric Center & Hospital
209	Liberty Medical Center (formerly listed as Provident Hospital)
205	Liberty Medical Center Psychiatric Center (formerly listed as Lutheran Hospital)
255	Lincoln Memorial Hospital
326	Loudoun Memorial Hospital, VA
354	Malcolm Grow U.S. Air Force Medical Center
280	Mary Washington Hospital, VA
206	Maryland General Hospital
281	Maryland Penitentiary Hospital
300	Maryland Poison Information Center at UMAB
285	Masonic Eastern Star Home, DC
566	McConnellsburg Hospital
332	McCready Memorial Hospital
339	McGuire Veteran's Administration Hospital, VA
398	Mechanicsburg Rehabilitation Hospital
774	Medlink, D.C.
404	Memorial Hospital, PA
567	Memorial Osteopathic Hospital, PA
207	Mercy Medical Center, Baltimore, MD
807	Mercy Medical Center, Neonatal Center - Baltimore, MD
907	Mercy Medical Center, Perinatal Center - Baltimore, MD
271	Monongahela General Hospital, WV
228	Montebello Center - Baltimore, MD
264	Montgomery General Hospital
282	Morgan County War Memorial Hospital, WV
287	Mount Vernon Hospital, VA
292	Mount Washington Pediatric Hospital
400	Myersdale Hospital, PA
351	Nanticoke Memorial Hospital
295	National Capital Poison Center, Washington, D.C. (formerly listed as National Capital Poison Center at Georgetown University, DC)
334	National Hospital for Orthopedics & Rehabilitation, VA
308	National Institute of Mental Health
356	National Institutes of Health Clinical Center
307	Newark Emergency Center, Newark, DE
568	Newark Hospital, NJ
762	Newmedico Rehabilitation
222	North Arundel General Hospital

Appendix A
Hospital Codes

753	Northampton-Accomac Memorial Hospital
313	Northeast Georgetown Medical Center (see also Greater Northeast # 261)
315	Northern Virginia Doctor's Hospital, VA
218	Northwest Hospital Center
309	NRH Regional Rehabilitation @ Irving Street, Wash., D.C. (formerly listed as National Rehabilitation Hospital)
521	Office of the State Medical Examiner
888	Other facility
330	Parkwood Hospital (-- closed per Region V Office formerly listed as Clinton Hospital)
336	Patuxent River Naval Air Station Hospital (closed per Region V Office)
408	Peninsula Regional Medical Center
608	Peninsula Regional Medical Center, Trauma Center (formerly listed as Peninsula General Hospital Medical Center Adult Trauma Center)
301	Pennsylvania State University Hospital (Hershey Medical Center), PA
318	Perkins State Hospital
357	Perry Point Veteran's Administration Hospital
569	Pittsburgh Institute for Rehabilitation
362	Pocomoke City Medical Center
361	Pocomoke Family Health Center
338	Police & Fire Clinic, Washington, DC
325	Potomac Hospital, VA
401	Potomac Valley Hospital, WV
632	Prince George's Hospital Center (formerly listed as Prince George's General Hospital and Medical Center Adult Trauma Center)
232	Prince George's Hospital Center (formerly listed as Prince George's General Hospital and Medical Center)
832	Prince George's Hospital Center Neonatal Center
344	Prince William Hospital, VA
288	Providence Hospital, DC
378	Psychiatric Institute of DC
364	Psychiatric Institute of Montgomery County
634	R Adams Cowley Shock Trauma Center - Adult Trauma Unit
734	R Adams Cowley Shock Trauma Center - Hyperbaric Unit
735	R Adams Cowley Shock Trauma Center - Neurotrauma Unit
570	Reading Medical Center
571	Riverside Hospital, DE
311	Riverside Hospital, VA
365	Rosewood State Facility
461	Ruby Hospital Morgantown, WV
572	Sacred Heart Hospital, PA
573	Saint Agnes Burn Center, PA
212	Saint Agnes Hospital
812	Saint Agnes Hospital Neonatal Center
912	Saint Agnes Hospital Perinatal Center
366	Saint Elizabeth's Hospital, Washington, D.C.
303	Saint Francis Hospital, WV
213	Saint Joseph Hospital, MD
405	Saint Joseph Hospital, PA
367	Saint Luke Institute
333	Saint Mary's Hospital
265	Shady Grove Adventist Hospital
368	Sheppard & Enoch Pratt Hospital
294	Shore Health Systems, Dorchester General Hospital (formerly listed as Dorchester General Hospital)
297	Shore Health Systems, Easton Memorial Hospital (formerly listed as Easton Memorial Hospital)
324	Sibley Memorial Hospital, Washington, D.C.
750	Sinai Head Injury Rehabilitation Hospital
210	Sinai Hospital of Baltimore
610	Sinai Hospital of Baltimore Adult Trauma Center
810	Sinai Hospital of Baltimore Neonatal Center
910	Sinai Hospital of Baltimore Perinatal Center
770	Sinai Rehabilitation Hospital
772	Solomon's Nursing Home Center
360	Southern Chester County Medical Center, PA
343	Southern Maryland Hospital Center
643	Southern Maryland Hospital Center Adult Trauma Center (Trauma center closed per Region V Office)

Appendix A
Hospital Codes

369	Spring Grove State Hospital
406	Springfield State Hospital
370	Springwood Psychiatric Institute, VA
460	St. Francis Hospital, Wilmington DE
452	Stella Maris Hospice – Dulaney Valley Road - Timonium, MD
453	Stella Maris Hospice at Mercy Medical Center - Baltimore, MD
249	Suburban Hospital Association
649	Suburban Hospital Association Adult Trauma Center
763	Suburban Hospital, Inc., Skilled Nursing Facility
371	Tawes-Bland Bryant Nursing Center
574	Taylor Hospital, WV
312	Taylor Manor Hospital
372	TB Clinic
760	The Greenery
373	Tidewater Memorial Hospital, VA
374	U.S. Naval Medical Clinic, Annapolis (formerly listed as U.S. Naval Academy Primary Care Clinic)
576	U.S. Public Health Hospital, MD
375	U.S. Soldier's and Airmen's Home, DC
298	Union Hospital of Cecil County
214	Union Memorial Hospital
714	Union Memorial Hospital, Curtis Hand Center
615	University of Maryland Hospital Adult Trauma Center (No longer exists per Region III Office)
915	University of Maryland Medical System (formerly listed as University of Maryland Hospital Perinatal Center)
215	University of Maryland Medical System (formerly listed as University of Maryland Hospital)
815	University of Maryland Medical System Neonatal Center (formerly listed as University of Maryland Hospital Neonatal Center)
575	University of Pennsylvania Hospital
407	Upper Shore Mental Health Center
246	Veteran's Administration Hospital - Baltimore, MD
577	Veteran's Administration Hospital - Wilmington, DE
376	Veteran's Administration Medical Center, DC
275	Veterans Affairs Medical Center Martinsburg WV (formerly listed as Martinsburg V.A. Hospital and Newton T. Baker Hospital)
250	Walter Reed Army Medical Center, DC
377	Walter Reed Hospital Annex
552	War Memorial Hospital, Berkeley Springs W.V. (formerly listed as Berkeley Springs Hospital, W.V)
328	Washington Adventist Hospital
689	Washington County Health System Adult Trauma Center (formerly listed as Washington County Hosp. Assoc., MD, Adult Trauma Center)
789	Washington County Health System, Comprehensive Inpatient Rehabilitation Services, MD
289	Washington County Health System, MD (formerly listed as Washington County Hospital Association, MD)
764	Washington County Health System, Skilled Nursing Facility, MD
727	Washington Hospital Center Burn Center, Washington DC
327	Washington Hospital Center, DC
728	Washington Hospital Center, DC, Adult Trauma Center
269	Waynesboro Hospital (formerly listed as Waynesboro General Hospital, Waynesboro, PA)
323	West Virginia University Hospital, WV
290	Western Maryland Center, MD
320	Western Maryland Health System Cumberland Campus (formerly listed as Cumberland Memorial Hospital & Medical Center)
620	Western Maryland Health System Cumberland Trauma (formerly listed as Cumberland Memorial Hospital & Medical Center Trauma)
321	Western Maryland Health System Sacred Heart Hospital Campus (formerly listed as Sacred Heart Hospital)
402	Western Pennsylvania University Hospital, PA
283	Winchester Medical Center
578	Woodrow Wilson Rehabilitation Center, VA
579	Yale - New Haven Hospital
272	York Hospital, PA
765	York Rehabilitation Hospital, PA

Appendix B
MAIS Jurisdiction Codes

01 Allegany County
02 Anne Arundel County
03 Baltimore County
04 Calvert County
05 Caroline County
06 Carroll County
07 Cecil County
08 Charles County
09 Dorchester County
10 Frederick County
11 Garrett County
12 Harford County
13 Howard County
14 Kent County
15 Montgomery County
16 Prince George's County
17 Queen Anne's County
18 Saint Mary's County
19 Somerset County
20 Talbot County
21 Washington County
22 Wicomico County
23 Worcester County
24 Baltimore City
25 B.W.I. Airport Transports
26 Neonatal Transports
27 Kirk Army Medical Center
28 Kimbrough Army Medical Center
29 City of Annapolis
31 M.S.P. Medevac Program
32 U.S. Park Police Medevac Program